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Health Reform Monitor

Primary care in Ontario, Canada: New proposals after 15 years of reform[☆]



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ABSTRACT

Primary care has proven to be extremely difficult to reform in Canada because of the original social compact between the state and physicians that led to the introduction of universal medical care insurance in the 1960s. However, in the past decade, the provincial government of Ontario has led the way in Canada in funding a suite of primary care practice models, some of which differ substantially from traditional solo and group physician practices based on fee-for-service payment. Independent evaluations show some positive improvements in patient care. Nonetheless, the Ontario government's large investment in the reform combined with high expectations concerning improved performance and the deteriorating fiscal position of the province's finances have led to major conflict with organized medicine over physician budgets and the government's consideration of an even more radical restructuring of the system of primary care in the province.

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1. Medicare and constraints on primary care reform in Canada

For historical and structural reasons, primary care has been extremely difficult to reform in Canada. When universal medical care coverage was introduced in Canada, for the first time in the province of Saskatchewan in 1962, organized medicine was highly opposed to the policy, considering it a potential threat to clinical decision-making and professional autonomy over patient billing. A 23-day doctors' strike ensued and was only terminated with a

compromise known as the Saskatoon Agreement that protected the status of doctors as independent contractors paid on fee-for-service (FFS) within the new system. A corollary of the compact is that, henceforth, doctors would negotiate for fee increases directly with the provincial government and would have considerable influence in deciding which new health services or procedures should be included in the basket of universally covered medical care services. Ensuring the privileged position of physician services, the Saskatoon Agreement became the template on which general tax-based universal "medicare" was introduced in the rest of Canada when the federal government provided some national standards in return for sharing provincial medical care expenditures [1].

For the rest of the twentieth century, primary care was largely delivered by physicians working in solo practice or in small physician groups sharing premises and overhead expenses. The focus was on basic medical services with

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few incentives for illness prevention and health promotion. After hours care was variable, limited and sometimes absent, forcing patients with minor illnesses into hospital emergency departments off hours and on weekends. The restriction of coverage under medicare to physician and hospital services and FFS physician payment strongly discouraged the involvement of other health professions in the delivery of primary care.

By the beginning of the 21st century, the lack of progress of primary care reform in Canada was obvious to experts in the field as well as decision-makers. Although there has been renewed interest in reforms over the past 15 years, these efforts have remained incremental and have not resulted in any major system changes in terms of governance, in particular, how primary care policy is formulated and implemented and how resources are allocated to primary care providers and organizations [2,3]. Moreover, based on patient assessment of selected primary care indicators and attributes used in the Commonwealth Fund's surveys of international health policy, Canadian performance relative to other OECD countries has been consistently weak, particularly in timely access to care and primary care infrastructure (clinical information systems, interprofessional teams, performance measurement and feedback, and quality improvement support) [4–6].

Canada is a decentralized federation and primary care policy is largely within the legislative purview of provincial governments, even if some of the conditions for universal coverage are under a federal law known as the Canada Health Act [7]. As a consequence, primary care reform is more usefully evaluated at a provincial rather than a national level. Compared to other OECD countries, the depth of primary care reform has been limited by the constraints of the Saskatoon Agreement.

2. Background: primary care reform in Ontario since 2002

Although still best described as incremental in approach, one province – Ontario – stands out in terms of the provincial government's single-minded focus on primary care. The pace of these reforms has been remarkable and the content of the reforms have begun to break with the constraints of the original Saskatoon Agreement. Since 2002, the Government of Ontario has launched a number of primary care models to increase access and improve the quality and delivery of primary care services. Ontario's investments in primary care reform were partly enabled by federal government funding provided through the Primary Health Care Transition Fund (2000–2003) and the Health Reform Fund targeting primary health care, home care and catastrophic drug coverage in 2003.

The provincial government has relied heavily on changes in physician remuneration and the provision of performance incentives and bonuses to achieve its aims [8]. Between 2007 and 2009, total payments to primary care physicians increased by 32% (compared to a 23% increase in overall provincial government health care expenditures), related mainly to the introduction and spread of the new reimbursement models [9]. The primary care share of health care expenditures rose from 7.5% to 8.1% during this

period [9]. Mean payments per full time equivalent primary care physician (unadjusted for inflation) increased by 31% between 2005 and 2009, compared to an increase of 25% for all Ontario physicians [10]. An important result of the introduction of new remuneration models and increased payments to primary care physicians has been to reverse the sharp decline in graduating physicians entering primary care that occurred during the 1990s.

However, relative to the substantial public investment made, the reforms have not yet produced the level of improvement in access and quality of care that the provincial government originally expected. As a consequence, the provincial government agenda is now focused on containing costs while potentially broadening the reforms to include potential structural changes that could require more direct accountability of primary care teams to the provincial government as discussed in the final section. This article reviews the original reforms and the rethinking spurred by mixed assessments of the results, and a potential major recalibration of the reforms that could have a substantial impact on primary care reform throughout Canada.

Prior to 2002, Ontario was almost identical to all provinces in that primary care was dominated by FFS doctors in solo and small group practices. The only exception to this was the proportionately small amount of primary care delivered by salaried practitioners working in government-owned but community-governed health centres targeting poor and marginalized populations. Beginning in 2002, the Ontario government introduced a number of new models of care based on three predominant forms of remuneration – fee-for-service (FFS), capitation and salary as illustrated in Table 1 [11].

To offset the incentives produced by any one system of remuneration, the predominant form was blended with elements of the other systems. In addition, bonuses and pay-for-performance targeted financial incentives were offered in all the models in order to encourage certain desired behaviours, in particular, the provision of after hour coverage for rostered patients, the provision of targeted services (e.g. mental health care, palliative care, cancer screening), and the establishment of key primary care infrastructure including the implementation of electronic medical records.

Uptake of the new models by primary care physicians has accelerated during the past decade. In 2002, 94% of Ontario's primary care physicians were remunerated through FFS [11]. By 2015, less than a quarter remained in traditional FFS and almost half of those FFS physicians provided specialized services (e.g., palliative care, sports medicine, hospitalist care, psychotherapy) rather than full-service primary care.

The capitation- and team-based models have disproportionately attracted physicians serving more affluent, healthier and lower-cost populations, raising equity concerns [12–14], not surprisingly given the lack of case-mix adjustment in the age-sex based capitation formula. However, Rudoler et al. found no evidence that physicians in capitation-based models are reducing the care they provide to sick and high cost patients [14]. In addition, although primary care physician density has increased substantially

Table 1

Primary care models in Ontario and key reform characteristics, 2002–present.

Model (year established)	Description and (number *and % of family physicians in brackets)	Remuneration	Roster-ing**	Professional team	After hours requirement
Family Health Group (2003)	3 or more physicians providing primary care to rostered patients with after hours coverage provided through a combination of limited direct service and telephone health advisory services (2565; 20.5%)	Fee-for-service (blended with targeted incentives and bonuses)	Yes	Limited	Required
Comprehensive Care Model (2005)	Solo physician providing primary care to rostered patients with some after hours care (377; 3.0%)			No	Not required
Family Health Network (2002)	3 or more physicians providing care to rostered patients with after hours coverage provided through a combination of limited direct service and telephone health advisory services (230; 1.8%)	Capitation (blended with targeted incentives and bonuses)		Limited	Required
Family Health Organization (2007)	Same as above (5033; 40.2%)	Same as above but with a broader basket of primary care services included in the capitation model		Limited	Required
Rural and Northern Physician Group Agreement (2004)	Special arrangement for primary care physicians dealing with dispersed population in rural and northern areas. (98; 0.8%)	Salary (blended with targeted incentives and bonuses)		Limited	Required
Nurse Practitioner-Led Clinic (2007)	Teams led by nurse practitioners (with collaborating physicians) to provide primary care services in communities with high numbers of patients not attached to a family physician (97 full-time equivalent nurse practitioners)	Salary (NPs) Sessional payment and FFS (Collaborating Physicians)	Yes, to the Clinic	Limited	Not required
Family Health Team (2005)	Inter-professional teams that go beyond doctors and nurses to include other health providers (e.g., nurse practitioners, dietitians, pharmacists, social workers, psychologists, occupational therapists) (2771 †; 22.1%)	Blended capitation (FHO or FHN model) or blended salary (Physicians) Salary (other health professionals)	Yes	Yes	Required (as per remuneration model)

Sources: Hutchison and Glazier [6], Price et al. [15] and Institute for Clinical Evaluative Sciences (Personal communication, Richard Glazier, November 18, 2015).

* As of September 1, 2015 (FHG, FHN, FHO, RNPGE), July 2015 (NP-Led Clinic, FHT); Personal communication, Phil Graham, Ontario Ministry of Health and Long-Term Care, October 19, 2015.

** Formal registration of patients with a primary care provider.

† These physicians are also included in the numbers for the FHN, FHO and RNPGE remuneration models as only physicians in those models are eligible to work in FHTs.

in Ontario (and throughout Canada) in the past decade, Ontario's primary care physician to population ratio (107 per 100,000) remains well below the Canadian average (114 per 100,000) [15].

Of all the models, the Family Health Team was described as “the provincial government's flagship initiative in primary care renewal” in large part because of the requirement to involve other professions beyond doctors and nurses such as social workers, psychologists, dietitians and pharmacists [3]. Physicians working in Family Health Teams (FHTs) are remunerated through capitation-based or salary-based blended payment models. Non-physician primary care health professionals working in FHTs (2149 as of December 2015 [Phil Graham, personal communication, February 25, 2016]) are salaried. The Family Health Team (FHT) model has proved attractive to a large number of physicians in Ontario [16]. However, due to the high cost of the model, the popularity of the FHT model has also put great fiscal pressure on the Ontario government at the very time it began to question whether it received adequate value for the investment made, as discussed in further depth below.

3. Implementation and results

By 2012, Ontario was investing in excess of \$1 billion per year in the new models of primary care, which enrolled 75% of the Ontario's population and 75% of primary care physicians. Included were 200 inter-professional FHTs providing services to 2 million provincial residents [17]. Improvements had been made in terms of expanding access beyond normal working hours, building primary care infrastructure including electronic medical records, expanding the pool of primary care providers, provision of targeted services that had previously been undersupplied, and more integrated and inter-professional primary care [7]. However, provincial decision-makers were becoming increasingly concerned about the growing cost of the reforms as well as the value for money proposition in terms of outcomes [18]. In its 2011 annual report, the provincial auditor general concluded that the province had not received value for money for its significant new expenditures on primary care doctors [9].

At the same time, there was no performance measurement system linked to the reforms thereby preventing an ongoing systematic evaluation of outcomes [11]. Instead, evaluations, mainly on particular dimensions, have been conducted on a piece-meal basis by external actors, including academics, and organizations that are arm's length from Ontario's Ministry of Health and Long-Term Care [3]. For example, the Centre for Health Economics and Policy Analysis at McMaster University evaluated the primary care payment incentives in the models. They found that the pay-for-performance incentives led to an increase (mostly modest) over baseline levels in the provision of four of five preventive services but that the special payments for the provision of priority services (e.g., obstetrical deliveries, palliative care, home visits) above specified thresholds had no effect [19].

Evidence regarding the impact of broader aspects of Ontario's primary care reforms has begun to emerge from

recent studies. Using longitudinal health administrative data, investigators from the Institute for Clinical Evaluative Sciences (ICES) observed improvements in cervical and colorectal cancer screening and diabetes care over the period 2004/5 to 2011/12 in all organizational and payment models, with FHTs and the capitation-based models (FHOs and FHNs) outperforming blended FFS and traditional FFS on almost every measure [20]. A five-year evaluation of FHTs found that organizational structures and processes associated with high primary care performance were strengthened between 2009 and 2012, but that patient-reported outcomes across multiple domains of patient experience (access, care coordination, patient and family centredness, prevention and health promotion and support for management of chronic conditions) were unchanged [21]. A longitudinal evaluation of population-based data (almost 10.7 million patients) found that patients in team-based capitation practices were more likely to receive appropriate diabetes care and to be screened for cervical, breast and colorectal cancers in the final year of the study period than those patients in enhanced FFS (FHG and CCM) models, even after adjustment for patient and physician characteristics [22]. Over time, patients in team-based capitation practices showed greater improvement in recommended diabetes care and cervical cancer screening than patients in non-team capitation practices and enhanced FFS practices [22].

Comparisons with other provinces (which have invested less heavily than Ontario in strengthening primary care) suggest that Ontario's primary care reforms may be starting to bear fruit in terms of access to primary care services. In a recent poll of Canadian adults, Ontario respondents were more likely (91% vs. the Canadian average of 84%) than respondents from other provinces to report having a “regular family doctor or general practitioner” and more likely than all but one other province to report that they can get an appointment with their family doctor/GP “within a day or two” (35% vs. the Canadian average of 29%) [23]. Ontario respondents were also more likely than those from other provinces to rate the quality of medical services as excellent or very good (51% vs. the Canadian average of 48%). In the 2015 Commonwealth International Health Policy Survey of Primary Care Physicians in 10 countries, Ontario physicians were more likely than physicians from other provinces to report being able to provide same- or next-day appointments to “almost all” or “most” of their patients and to have an arrangement where patients can see a doctor or nurse after hours without going to the hospital emergency department [6].

Despite emerging evidence of progress, the anticipated results from the reform did not materialize as quickly as the government would have liked. This fact combined with the deteriorating fiscal position of the province's finances due to the earlier fiscal crisis, has led to public sector pay freezes and difficult negotiations with Ontario doctors.

4. Current issues and developments

Relations between the provincial government and the Ontario Medical Association (OMA) have become particularly acrimonious in the last 12 months. Negotiations

Table 2
Contrasting System Design for the Reform of Primary Care in Ontario.

Primary Health Care Expert Advisory Committee (Price) Report, 25 Feb. 2015	Ontario Government's Patient First Discussion (i.e. White) Paper, 17 Dec. 2015
<ul style="list-style-type: none"> Recommended that Ontario government create primary care fund-holding organizations known as primary care groups (PCGs) 	<ul style="list-style-type: none"> Provincial government did not embrace concept of fund-holding or the creation of PCGs
<ul style="list-style-type: none"> PCGs to contract with local primary care clinicians to provide broad range of primary health care services to PCG's assigned population 	<ul style="list-style-type: none"> The government instead proposed to increase responsibility of Local Health Integration Networks (LHINs) for population health, public health and community care, including primary care planning and performance management Smaller sub-regions to be identified within LHINs as the focus for local planning and service management and delivery LHINs would be expected to partner with clinical leaders in order to better integrate and coordinate primary care with other programs and services The Ministry of Health and Long-Term Care would continue to negotiate physician compensation and primary care contracts with the OMA
<ul style="list-style-type: none"> PCGs to be funded by, and accountable to, geographically-based Local Health Integration Networks (LHINs) 	
<ul style="list-style-type: none"> LHINs continue to be funded by, and accountable to, Ontario's Ministry of Health and Long-Term Care 	<ul style="list-style-type: none"> Government proposes no changes in the funding and accountability relationship between LHINs and the provincial Ministry of Health and Long-Term Care

Sources: Price et al. [25] and Government of Ontario [28].

reached an impasse following the expiration of the 2012 physician services agreement in April 2014. Eventually, a conciliator, former chief justice of the Ontario Court of Appeal, was brought in to help the two parties find a solution. The government then tabled an offer, which was ultimately rejected by the OMA at the beginning of 2015 [24]. Since that date, the OMA and the provincial government have continued to wage a very public battle on the issue of remuneration, the doctors arguing that the government's cutbacks will negatively affect patient access to care while the government has argued that it must begin to reallocate scarce fiscal resources to other key areas such as social care, known in Canada as home care, community care and long-term care.

The government unilaterally implemented cuts to physician payments in February 2015 and again in October 2015, totaling approximately 7%. In response to the unilateral actions of the government, the OMA launched a court challenge under the Canadian Charter of Rights and Freedoms in late October, asking the court to strike down the government's unilateral actions and to order the government to establish a new negotiations framework that includes binding dispute resolution (to replace the current non-binding conciliation process).

The government is also currently considering the report of the Primary Health Care Expert Advisory Committee, an expert panel it established in 2013 "to address current challenges in Ontario's primary care system". In particular, the Expert Advisory Committee was to address four policy questions [25]:

- How can all Ontario residents be rostered?
- How can all residents who need the services of an inter-professional primary care team obtain them?
- How can integration among primary care providers and between primary care providers and other health system providers and organizations be improved?
- How can residents be ensured that they receive primary care after business hours and on weekends when needed?

The Expert Advisory Committee delivered a draft report to the provincial government in February 2015 [25]. In addition to suggesting incremental improvements to the existing primary care models, the Committee recommended radical changes to governance and health system structure. Drawing on the experience in the National Health Service in the United Kingdom, the Committee proposed that the entire population of the province and all primary care providers be assigned to primary care fund-holding organizations (Patient Care Groups – PCGs) based on geography.

PCGs would contract with local primary care providers to deliver primary care services to the PCG's assigned population. Funds would be transferred to the PCG by the provincial government based on the socio-economic, geographic and demographic profile of the population it serves and then allocated to each provider group according to the terms of the contract. The PCGs would then be accountable to regional health authorities, known in Ontario as Local Health Integration Networks or LHINs, and through

the LHINs to the provincial ministry of health. However, given the lack of stakeholder consultation and engagement to date, the acceptability and feasibility of the model are untested.

By holding funds for core primary care services, the proposed model differs from other examples of local primary care governance (e.g., England's Clinical Commissioning Groups, Australia's Medicare Locals, New Zealand's Primary Health Organizations and British Columbia's Divisions of Family Practice). In those jurisdictions, payment for core services is negotiated by the national or, in British Columbia's case, the provincial government. In this and other respects, the model represents a strong challenge to medicare's founding bargain between the medical profession and the state. The OMA has already indicated its opposition to the model on the grounds that the PCG's "ability to determine physician funding violates the OMA's Representation Rights Agreement as set out in the 2012 Physician Services Agreement" [26]. The OMA has tabled an alternative model of primary care governance, which it calls the Integrated Health Network, that is designed to achieve horizontal integration of existing primary care models at the community level [27].

The provincial government subsequently released a discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, which proposes giving LHINs responsibility for "all health service planning and performance" and the identification of "sub-regions within LHINs that would be the focal point for local planning and service planning and delivery" – including, for the first time, physicians' services [28]. "The LHINs would work closely with primary care providers to plan services, undertake health human resources planning, improve access to inter-professional teams for those who need it most and link patients with primary care services." The proposal does not embrace the concept of local primary care fund-holding organizations, as recommended by the Expert Advisory Committee, stating that "[t]he ministry would continue to negotiate physician compensation and primary care contracts". The government has invited stakeholders to provide comment on the proposal. Table 2 compares the recommendations of the Expert Advisory Committee to the response of the Ontario government as reflected in its discussion paper.

5. Conclusion

It remains to be seen how the Ontario government will manage its current confrontation with Ontario physicians over primary care reform. If the Ontario government accepts and implements either the recommendations of its Expert Advisory Committee or the model outlined in *Patients First*, it will be the first province to alter the governance of primary care physicians since the introduction of medicare in the 1960s. Although the Ontario reform has altered payment mechanisms for primary care doctors more than any other provincial reform, it has not yet addressed the fragmentation, lack of voice and lack of collective accountability of primary care at the community level.

Whatever one thinks of the specific governance models proposed by the Expert Advisory Committee and the provincial government, the critical issue of local primary care governance is squarely on the table and can no longer be avoided. As the debate and discussion proceed, the great challenge will be to achieve an appropriate balance at all levels of bottom-up vs. top-down and incremental vs. "big bang" transformation, autonomy vs. accountability, support vs. sanctions, intrinsic vs. extrinsic motivation, and engagement vs. command and control.

References

- [1] Marchildon GP, Schrijvers K. Physician resistance and the forging of public health care: a comparison of the doctors' strikes in Canada and Belgium in the 1960. *Medical History* 2011;50:203–22.
- [2] Hutchison B, Abelson J, Lavis J. Primary health care in Canada: so much innovation, so little change. *Health Affairs* 2001;20:116–31.
- [3] Hutchison B, Levesque J-F, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. *The Milbank Quarterly* 2011;89(2): 256–88.
- [4] Aggarwal M, Hutchison B. Toward a primary care strategy for Canada. Ottawa: Canadian Foundation for Healthcare Improvement; 2012.
- [5] Osborn R, Moulds D, Schneider EC, Doty M, Squires D, Sarnak DO. Primary care physicians in ten countries report challenges caring for patients with complex health needs. *Health Affairs* 2015;12: 2104–12.
- [6] Canadian Institute for Health Information. How Canada compares: results from the Commonwealth Fund 2015 International Health Policy survey of Primary Care Physicians. Ottawa, ON: CIHI; 2016.
- [7] Marchildon GP. Health system review: Canada. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies; 2013.
- [8] Sweetman A, Buckley G. Ontario's experiment with primary care reform. Calgary: University of Calgary, The School of Public Policy Research Papers; 2014.
- [9] Office of the Auditor General of Ontario. 2011 Annual Report, Chapter 3, Funding Alternatives for Family Physicians. Toronto: Queen's Printer for Ontario; 2011. Available from: <http://www.auditor.on.ca/en/reports/en11/306en11.pdf>.
- [10] Henry DA, Schultz SE, Glazier RH, Bhatia RS, Dhalla IA, Laupacis A. Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources, 1992/93 to 2009/10. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2012.
- [11] Hutchison B, Glazier R. Ontario's primary care reforms have transformed the local care landscape: but a plan is needed for ongoing improvement. *Health Affairs* 2013;32(4):695–703.
- [12] Glazier RH, Zagorski BM, Rayner J. Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2012.
- [13] Rudoler D, Deber R, Barnsley J, Glazier RH, Dass AR, Laporte A. Paying for primary care: The factors associated with physician self-selection into payment models. *Health Economics* 2015;24(9):1220–42.
- [14] Rudoler D, Laporte A, Barnsley J, Glazier RH, Deber RB. Paying for primary care: a cross-sectional analysis of cost and morbidity distributions across primary care payment models in Ontario Canada. *Social Science and Medicine* 2015;124:18–28.
- [15] Canadian Institute for Health Information. Supply, distribution and migration of Canadian Physicians, 2014. Ottawa, ON: CIHI; 2015.
- [16] Moat KA, Lavis JN, Hutchison B. Learning from promising primary care practice models for the USA: a Canadian case study. Hamilton, ON: McMaster Health Forum, Centre for Training and Research Support Centre; 2014.
- [17] Glazier RH, Kopp A, Schultz SE, Kiran T, Henry DA. All the right intentions but few of the desired results: lessons on access to primary care from Ontario's patient enrollment models. *Healthcare Quarterly* 2012;15(3):17–21.
- [18] Deber R, Allin S. Ontario: changing policies, changing categories. In: Marchildon GP, Di Matteo L, editors. *Bending the cost curve in health care: Canada's provinces in international perspective*. Toronto: University of Toronto Press; 2015.
- [19] Hurlley J, DiCicca P, Li J, Buckley G. The response of Ontario primary care physicians to pay-for-performance incentives. Hamilton, ON: McMaster University Centre for Health Economics and Policy Analysis working paper; 2011.

- [20] Glazier RH, Hutchison B, Kopp A. Comparison of Family Health Teams to other Ontario primary care models, 2004/05 to 2011/12. Toronto: Institute for Clinical Evaluative Sciences; 2015.
- [21] The Conference Board of Canada. Final report: an external evaluation of the Family Health Team (FHT) initiative. Ottawa: The Conference Board of Canada; 2014.
- [22] Kiran T, Kopp A, Moineddin R, Glazier RH. Longitudinal evaluation of physician payment reform and team-based care for chronic disease management and prevention. *CMAJ* 2015;187(17):E494–502.
- [23] Angus Reid Institute. Election 2015: the politics of healthcare. Angus Reid Institute; 2015. Available at: <http://angusreid.org/election-2015-the-politics-of-healthcare/>.
- [24] Government of Ontario news release. Statement by Ontario's Health Minister on negotiations with the Ontario Medical Association, Ministry of Health and Long-Term Care; 15 Jan. 2015.
- [25] Price D, Baker E, Golden B, Hannam R. Patient care groups: a new model of population based primary health care for Ontario. Toronto: Primary Health Care Expert Advisory Committee confidential draft; 11 Feb. 2015.
- [26] Ontario Medical Association. MOHLTC Commissioned Primary Health Care Advisory Committee Report (email to OMA members). Toronto: Ontario Medical Association; October 2, 2015.
- [27] Ontario Medical Association. An integrated health network approach to address priority populations in family practice in Ontario. Toronto: Ontario Medical Association; June 2015.
- [28] Government of Ontario. Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario. Toronto: Government of Ontario; December 17, 2015. Available at http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf.